



Acknowledgement of Receipt of Notice of Privacy Practices

Signature: _____ Date: ____/____/____

Print Name: _____ Date: ____/____/____

If not signed by the patient, please indicate who signed:

- Parent or guardian of minor patient
- Guardian or conservator of an incompetent patient
- Beneficiary or personal representative of deceased patient

Name of Patient: _____

Confidential Contact Information

- If it becomes necessary to contact you by phone, do we have your permission to leave messages regarding lab results and/or appointments on your answering machine or voicemail? Yes or No

- What is the best time of the day to reach you? _____

- Where do you prefer to receive our call? Home Work Mobile phone

- Name and number of emergency contact person that does not live with you:

Name: _____ Date: ____/____/____